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LUPUS VULGARIS WITH TUBERCULOSIS VERRUCOSA CUTIS

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26 years old male presented with two large plaques of lupus vulgaris and a lesion of tuberculosis verrucosa cutis on the right thigh and foot, respectively. Both the lesions were confirmed by histopathological examinations.

Key words : Lupus vulgaris, Tuberculosis verrucosa cutis

Introduction

Skin is one of the portals of entry of Mycobacterium tuberculosis. Cutaneous tuberculosis constitutes only a small fraction of extra pulmonary tuberculosis. Tuberculosis verrucosa cutis (TVC) and lupus vulgaris (LV) arise in a person with moderate or high degree of immunity. TVC occurs as a large verrucous plaque with finger like projections at the margins. LV presents usually as a single soft, flat infiltrated plaque, with apple jelly nodules at the edge. Haematogenous forms as well as exuberant granulomatous forms of TVC have been described.[1,2] In India LV is the commonest type of secondary tuberculosis of the skin.[3] Disseminate forms of LV are not uncommon.

Case Report

A 26-year-old farmer presented with history of skin lesions on the right lower limb for three years. The lesion initially appeared on the right foot as a small papule which became verrucous and gradually enlarged in size. Six months later he noticed two other lesions on the right thigh and right groin. On examination there were three large plaques on the right groin, thigh and foot. The right foot lesion measuring 6 x 8 cms in size was verrucous at the edges and showed depigmentation and atrophic scarring at the centre (Fig. 1). Right thigh and groin lesions were smooth plaques measuring 5 x 4 cms in size with central atrophy. Apple jelly nodules were seen at the margins (Fig. 2). Investigations revealed a normal haemogram and chest X-ray. PPD was positive (15 x 15 mms in size). HPE from the right foot was consistent with TVC with marked hypertrophy of the epidermis and mid-dermal granulomata

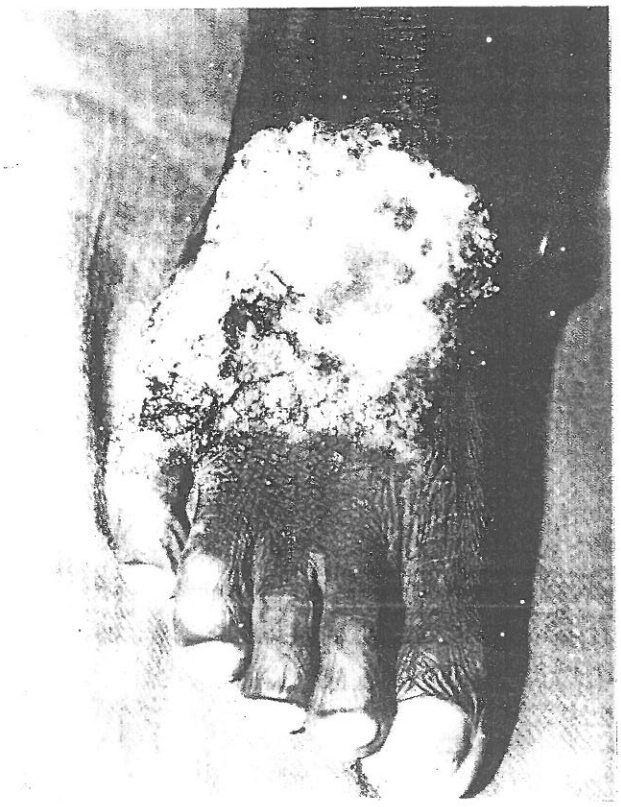

Fig. 1. Right foot verrucous lesion.

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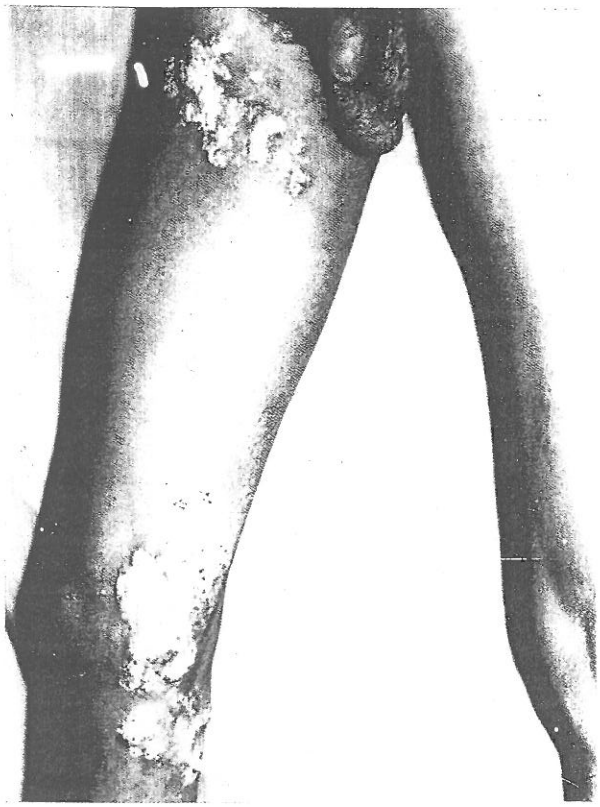

Fig. 2. Right thigh & groin lesions of lupus vulgaris.

with Langhans giant cells (Fig. 3). The other lesions were consistent with LV with minimal acanthosis, hyperkeratosis and granulomata spread over upper dermis. The patient was diagnosed to have disseminated LV with TVC. He was treated with three antituberculosis drugs like rifampicin, isoniazid and ethambutol. Within three months the verrucous lesion on the right foot completely flattened out whereas the other lesions resolved partially. At the end of 18 months all the lesions resolved well and there was no recurrence during the follow up period of two years.

Comments

LV and TVC can be differentiated by the presence of apple jelly nodules at the edges in the former and the scaly verrucous nature of lesions in the latter.[3] Histopathology of LV

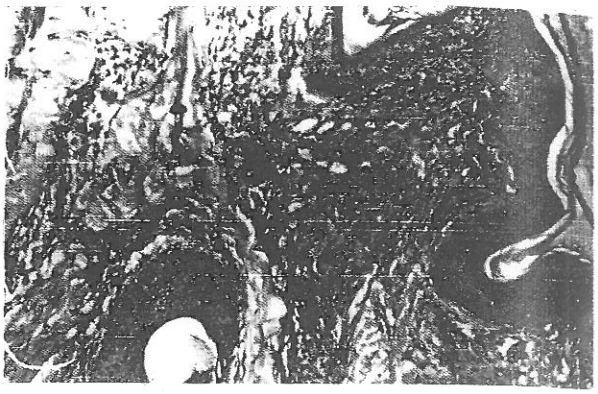

Fig. 3. Tuberculoid structures in the Dermis. H & E x 40.

predominently shows mononuclear infiltration and upper dermal tubercles or tuberculoid structures whereas TVC shows neutrophilc infiltrate and mid dermal tuberculoid granulomata. Our patient showed features of these seperately at the different sites. The marked response of the warty tuberculosis to antituberculosis drugs in our patient when compared to the other two plaques of LV confirms the diagnosis of two different types of cutaneous tuberculosis in the same patient. The possible mode of spread of Mycobacterium tuberculosis might be through lymphatic dissemination as the lesions showed a predilection in that pattern. The association of disseminated LV with TVC in a single patient has not been reported so far.

References

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